Claims Submission

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All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements outlined in the Claims Submission section of the All-Provider Handbook.

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Electronic Claims Submission

Providers who dispense disposable medical supplies (DMS) are encouraged to submit claims electronically. Electronic claims submission:

- Eliminates manual handling of claims.
- Reduces both billing and processing errors.
- Reduces processing time.

Wisconsin Medicaid provides free software for submitting claims electronically.

Providers who electronically submit claims are required to complete an Electronic Media Agreement Form. The form serves as the provider's signature. For more information on the Electronic Media Agreement Form, Wisconsin Medicaid's requirements for electronic claims submission, and general electronic claims submission information:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746 and ask to speak with an EMC coordinator.

If you are currently using the free software and have technical questions, please contact Wisconsin Medicaid's software customer service at (800) 822-8050.

Paper Claims Submission

Providers submitting paper claims are required to use the CMS 1500 claim form (dated 12/90). Refer to Appendix 1 of this handbook for CMS 1500 claim form completion instructions. Appendix 2 of this handbook contains a completed sample of a CMS 1500 claim form for DMS services. Wisconsin Medicaid denies claims for DMS submitted on any paper claim form other than the CMS 1500 claim form.

Wisconsin Medicaid does not provide the CMS 1500 claim form. Providers may obtain copies of this form from vendors who sell federal forms.

Where to Send Your Claims

Mail completed CMS 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
6406 Bridge Rd
Madison WI 53784-0002

Claims Submission Deadline

Wisconsin Medicaid will only consider for reimbursement complete and correct claims that are received within 365 days from the date the services were provided. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claims submission deadline and requirements for submission to Late Billing Appeals may be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook online at *www.dhfs.state.wi.us/medicaid/*.

Coordination of Benefits

Generally, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service.

If the recipient is covered under other insurance (including Medicare), Wisconsin Medicaid reimburses that portion of the allowable cost remaining after all other insurance sources have been exhausted.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more detailed information on submitting claims to commercial health insurance and Medicare.

Medicare / Medicaid Dual Entitlement

Medicare may reimburse for DMS under Part B coverage. *Medicare*-certified providers are required to submit claims to Medicare prior to submitting claims to Wisconsin Medicaid for all DMS provided to dual entitlees or Qualified Medicare Beneficiary-Only (QMB Only) recipients.

The following providers are required to be certified by Medicare if they intend to provide a Medicare-covered service to a dual entitlee:

- Home care agencies.
- Medical equipment vendors.
- Pharmacies.
- Physicians.

In these instances, if the provider is not certified by Medicare, he or she should refer the dual entitlee to another Medicaid provider who is also Medicare-certified.

Refer to the Claims Submission section of the All-Provider Handbook for more information on dual entitlees and QMB-Only recipients.

Billed Amounts

Providers are required to bill their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median (i.e., 50% of charges are above and 50% below) of the individual provider's charge for the service when provided to non-Medicaid patients. Providers may not discriminate against Wisconsin Medicaid recipients by charging Wisconsin Medicaid a higher fee for the same service than that charged to a private-pay patient.

For providers that have not established usual and customary charges, the charge should be reasonably related to the provider's cost to provide the service.

Providers are required to bill their usual and customary charge for the service performed.

Recipient Copayment

Recipients are responsible for paying a copayment for all purchased DMS. The copayment schedule is based on each order per date of service (DOS). The copayment schedule is as follows:

Maximum Allowable Fee, per Procedure Code	Copayment Amount, per Date of Service
Up to $10.00	$0.50
From $10.01 to $25.00	$1.00
From $25.01 to $50.00	$2.00
Over $50.00	$3.00
Urine or blood test strips	$0.50

Providers are required to request the copayment amount from recipients; however, they may not deny services to a recipient who fails to make a copayment.

Wisconsin Medicaid copayment amounts should not be deducted from charges submitted to Wisconsin Medicaid, nor should these copayment amounts be indicated in the "paid by other" element on claims submitted.

The diagnosis code must be appropriate for the service provided.

Providers are reminded that the following services are exempt from copayment requirements:

- Emergency services.
- Family planning services and related supplies.
- Hospice care services.
- Home care services.
- Hearing aid batteries.
- Services covered by a Medicaid managed care program provided to enrollees of the managed care program.
- Services provided to a pregnant woman if the services are related to the pregnancy.
- Services provided to nursing home residents.
- Services provided to recipients under 18 years of age.

Please refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information on recipient copayment requirements.

Referring Providers

Claims for DMS (except for hearing aid batteries) require the referring provider's name and a Universal Provider Identification Number, license, or provider number in Elements 17 and 17a of the CMS 1500 claim form.

Diagnosis Codes

All claims require a diagnosis code. All diagnoses must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure. The diagnosis code must be appropriate for the service provided.

Claims received without an appropriate ICD-9-CM code are denied.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to Wisconsin Medicaid.
- Codes with an "M" prefix are not acceptable on a claim submitted to Wisconsin Medicaid.

Procedure Codes

To be eligible for Wisconsin Medicaid reimbursement, all claims for DMS submitted to Wisconsin Medicaid must use Health Care Procedure Coding System (HCPCS), formerly known as "HCFA Common Procedure Coding System," National Level II codes or Wisconsin Medicaid local codes that are allowable for the DOS. Disposable medical supplies claims or adjustments received without the appropriate procedure codes are denied.

Seeking Reimbursement for Items That Are Not Listed in the Disposable Medical Supplies Index

In some circumstances, the DMS Index may not list the exact procedure code for a requested supply. Providers are required to obtain prior authorization (PA) from Wisconsin Medicaid for requested supplies that are not listed in the DMS Index.

If Wisconsin Medicaid approves the PA request, the provider will receive a copy of the approved Prior Authorization Request Form (PA/RF) with the procedure code and modifier. Providers should submit claims using the *same* procedure code and the modifier given on the approved PA.

For instance, if the DMS Index does not list a four-way indwelling catheter, foley type for continuous irrigation, the provider would use the HCPCS procedure code A4346 (indwelling catheter, foley type; three-way for continuous irrigation), with the modifier "PA" given on the approved PA/RF.

Refer to the Prior Authorization chapter of this handbook for more information on obtaining PA.

"Not Otherwise Classified" Procedure Code

As described in the Prior Authorization chapter of this handbook, providers are required to use the "not otherwise classified" (NOC) procedure code (W6499) when seeking PA for items that do not have a specific or similar procedure code.

Providers should use this NOC procedure code when submitting claims to Wisconsin Medicaid after the PA is approved and the DMS are dispensed.

Place of Service and Type of Service Codes

All claims for DMS submitted to Wisconsin Medicaid are required to include type of service (TOS) "9"* and valid place of service (POS) codes. The POS codes are listed in Appendix 1 of this handbook.

*Claims for exceptional supplies should not include TOS "9." Instead, they are required to include TOS "P" for purchased items or "R" for rented items.

Exceptional Supplies for Nursing Home Recipients

Refer to Appendix 3 of this handbook for an explanation on submitting claims for exceptional supplies for nursing home recipients.

Reimbursement

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee established by the Division of Health Care Financing. Providers are reminded that they cannot seek payment from recipients for any difference between their billed amount and the maximum allowable fee.

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code. The maximum allowable fee schedule is contained in the DMS Index. (For more information on the DMS Index, refer to "Explanation of the Disposable Medical Supplies Index" in the Covered Services chapter of this handbook.)

Reimbursement for Disposable Medical Supplies Provided to Nursing Home and Home Care Recipients

Most DMS are included in the nursing home daily rate and are not separately reimbursable when provided to nursing home recipients. In some instances, DMS are included in the home care visit rate and are not separately reimbursable when provided to home care recipients.

The DMS Index indicates which items are included in the reimbursement for nursing home and home care services.

For example, Wisconsin Medicaid will not separately reimburse for gloves used by providers to provide care to nursing home and home care recipients because the gloves are included in both the nursing home daily rate and the home care visit rate.

All Occupational Safety and Health Administration-mandated and other infection-control supplies are also included in the nursing home daily rate and the home care visit rate. Wisconsin Medicaid will not provide separate reimbursement for these supplies when they are used by nursing home and home care staff. Home care providers are expected to include supplies only during the billable hours services are delivered. They are not expected to provide recipients with supplies for use when they are not directly delivering billable home care services.

The DMS Index indicates which items are included in the reimbursement for nursing home and home care services. Refer to "Explanation of the Disposable Medical Supplies Index" in the Covered Services chapter of this handbook for more information on how to read the DMS Index.

Follow-Up to Claims Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim so that Wisconsin Medicaid receives the claim for processing within 365 days of the date of the original service.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for more information on filing Adjustment Request Forms.